Testimony on Medicaid Reform
House Energy and Commerce Committee

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September 8, 2005

Before I turn to the issues surrounding Medicaid Reform, it would be useful to take a moment to consider the characteristics of the Medicaid program as it stands today. Started in 1965 as a program to provide health benefits to the welfare population, today less than 25% of the recipients on Medicaid receive cash assistance. By providing health coverage to 38 million children and parents in low income working families, Medicaid and its sister program, SCHIP, has played a vital role as the health insurance safety net in an economic environment where more and more Americans are being priced out of health insurance in the private market. Despite these recent expansions, a staggering 45 million Americans today have no health insurance.

These numbers are important in today's debate. Medicaid is asked to do many things. It is the insurer of last resort for poor and working families. It is the mainstay of persons with disabilities struggling to live in the least restrictive environment. It is, in effect, our national long term insurance program, not only for the poor but for the middle class and the affluent who divest themselves of assets when nursing home costs are looming in their near future. And yet all of these populations are held to the same standards for coverage, the same limits on cost sharing, and the same benefit packages in the absence of specific federal waiver authority. For a program this large and this diverse, greater flexibility to define eligibility, benefits and cost-sharing for those populations with household incomes above the poverty level is necessary in order for Medicaid to participate in broader health care reform.

We should take pride in what Medicaid has accomplished while incurring an administrative cost ratio that would be the envy of any private insurer. Indeed, the recent articles about Medicaid fraud are stark evidence that higher administrative costs would be well justified as a means of rooting out fraud and insuring that tax dollars go to the purposes for which they were intended.

It is the relationship of Medicaid to the uninsured that is the strongest rationale in my mind for reform. Between 2000 and 2005 the national Medicaid caseload increased by an astounding 40%. Medicaid now provides benefits to 53 million people at a cost of over $350 billion a year. It is the ultimate recipient of bad selection, the largest payer of long-term care, and the last alternative for families that lose private health insurance.

Reform strategies work. Between 2000 and 2003 states pushed ahead with at times unpopular measures such as mandatory enrollment in managed care, pharmacy prior authorization, and

preferred drug lists. During that period of unprecedented enrollment growth, Medicaid acute care costs increased by only 6.9% annually. The rates for employer-sponsored insurance increased by 12.6% through the same period. You cannot look at those figures and fail to understand that Medicaid has absorbed the abandonment of family coverage for low-income workers from the private sector, and that Medicaid has needed all the tools in the cost containment toolbox to enable it to do so.

We are only a few years away from a demographic tsunami that will send millions of baby-boomers like me into the public programs for long-term care benefits. Many in my generation still believe that new pharmaceuticals will keep them young. They won't, but they will cost a fortune. Many of my peers believe that Medicare and retirement benefits will secure them against long-term care costs in their golden years of assisted living bliss. The more likely outcome is a semi-private room in a skilled nursing facility with Medicaid picking up the tab. In a program where 50%

of all expenditures currently go for institutional long-term care, this demographic prospect is scary. Left unchanged it will set up a political tension between our children and ourselves that will test the bounds of their affection for us as they see their own retirements forestalled and their FICA deductions from their paychecks increased.

Most importantly to me, this competition for resources from an aging population will inhibit further efforts by the states to address the problem of the uninsured. We are lucky in Connecticut. We live in one of the richest states in the country. We have an abundance of medical providers compared to states in rural and frontier areas. Despite the vicissitudes of the budget battles over the past decade, we still offer broad coverage for the poor that goes beyond what Medicaid is willing or able to match with federal dollars. Our state-funded SAGA medical program provides comprehensive coverage to over 30,000 single adults who do not meet the categorical requirements for Medicaid, despite their very

low income. Our ConnPACE program provides state funded assistance for the cost of prescription drugs to over 50,000 senior citizens. Our SCHIP program provides coverage to uninsured children up to 300% of the federal poverty level with a buy-in for parents with household incomes above that. Medicaid covers children and pregnant women with household incomes up to 185% of the federal poverty limit without an asset test and parents up to 150%. We have a Breast and Cervical Cancer program that serves all uninsured women who are unfortunate to have either of those diagnoses, regardless of their income level. We have a medically needy program that through the bewildering process of spend-down does provide coverage to thousands of disabled adults and nursing home patients. As we sit here today, these programs together serve nearly half-a-million of our neighbors. One out of every ten residents of our state receives assistance through the HUSKY program for families and children. One quarter of all the births in the state each year are funded by that same program. Seventeen thousand seniors receive home care as an alternative to

institutional care under our federal waivers. Two-thirds of all the patients in nursing home beds right now are supported by Medicaid. We are currently working to expand coverage for children with special health care needs, to provide more alternatives in the community for persons with cognitive disabilities, to expand access to mental health services for children, and to provide family planning services to all uninsured women with incomes below 185% of poverty.

We can do these things in Connecticut because we have the resources, despite the fact that we receive the minimum federal match rate of 50% on our Medicaid expenditures. Just like every other state, we struggle with budget priorities every year, balancing the growth in the percentage of the General Fund that goes to the Medicaid program against other priorities like education and public safety. This year Connecticut, like a growing list of other states, will spend more on Medicaid than it does on education, a first for our state. We continue to do these things in the face of a Medicaid

regulatory environment that makes it all but impossible to implement many of the cost containment strategies that are currently employed by the private sector in providing care to comparable populations.

But don't assume that same situation pertains in other states. Many states simply have no option to increase revenues and no further state expenditures to capture under a Medicaid claim, regardless of the federal match rate. As you watch the implementation of Medicare Part D, its is the poor states that will feel most acutely the impact of clawback payments to the federal government on their dual eligible population with no off-setting savings on the pharmacy costs of state retirees or on a State Pharmacy Assistance Program like ConnPACE, either of which would have been historically unaffordable. States in the hurricane devastated areas in the Gulf face nearly insurmountable difficulties in providing medical care to the survivors in the midst of an economic and environmental catastrophe. The Centers for Medicare and

Medicaid Services should immediately set aside any thought of special waivers for presumptive eligibility for the host states that are receiving refugees from the storm ravaged areas and authorize 100% federal reimbursement for the cost of providing immediate temporary Medicaid assistance to our displaced fellow countrymen and women.

Medicaid reform is a moral imperative that demands that reasonable measures be taken now to allow the states the time and resources to respond to the challenges of an aging population, a growing number of uninsured, and unprecedented, unanticipated events like 911 and Hurricane Katrina and the attendant economic dislocation.

Here is my short list of what needs to be on the table in terms of future Reform:

1. **Continue the expansion of managed care** – Like it or not, this is where most of us now receive our care. Despite nostalgic fondness for the golden age of fee-for-service, anyone who is objective about the improvements in access and quality of care purchased from accountable networks will have to conclude that managed care works for Medicaid populations.

2. **Remove the federal barriers to the innovative management of the dual eligibles** – 45% of all Medicaid expenditures are for recipients enrolled in another comprehensive federal health care program known as Medicare. The current system fails to reward the states for innovative strategies like disease management or managed care that ultimately benefit the Medicare budget. This makes no sense from either a state or a federal perspective, especially with the impending retirement of the baby boom generation. States should be able to count Medicare savings

towards their cost effectiveness calculations for their waiver applications that would impact the cost of care for this very high cost population.

3. **Expand state flexibility on benefit design and cost sharing for populations above the poverty level** – You cannot convince families to take an interest in the cost of their care unless they share in it, however marginal that contribution might be. Clients, like the rest of us, should have an economic stake in maintaining wellness. Penalty-free inappropriate use of the emergency room does no one any good. Pharmaceutical utilization should be based on need, not advertising. And premiums for expansion populations are a small contribution when measured against the value of the benefit that is conferred. In Connecticut, the recent history of parents eligible for our HUSKY program with household incomes between 100 and 150% of the poverty level - on the program, off the program, back on the program with a

monthly premium – demonstrates that it is better to offer working families coverage with higher cost sharing, than no coverage at all. Preserve the existing limits on Medicaid cost sharing for populations with household incomes below the poverty level, but give states the option of making them enforceable. Give states the option of imposing greater cost-sharing, including things like tiered co-payments for prescription drugs, for populations above the poverty level. Make it affordable for states to assist the working poor with coverage that is comparable to the coverage that is available to their peers through their place of work.

4. **Restrict Asset Transfers** - It is morally wrong to impose cost sharing and other cost containment measures on the poor when people of means can utilize trusts or a broken policy on the penalty period for inappropriate asset transfers to qualify for Medicaid when they need long-term care. Connecticut submitted a waiver that would start the penalty period at the

point of entry into a long-term care facility, rather then when the inappropriate transfer actually occurred, in some cases years prior to the fact. This measure alone has been scored by the Congressional Budget Office as having the potential to save $1.4 billion nationally over the next five years. In Connecticut and in the other waiver states we are waiting to see what will transpire at the federal level, since this is such a significant change in how eligibility for long-term care is calculated. Connecticut is one of four states that are currently allowed to grant asset protection to people who insure themselves against the cost of long-term care under our Long Term Care Insurance Partnership. This authority should be granted to other states either under a waiver authority or a State Plan Amendment option to encourage individuals to insure themselves against such an eventuality. Grant tax incentives or other inducements if necessary. But we must change the mindset that long-term care under Medicaid is a

middle-class entitlement that people have no responsibility to insure against.

5. **Maximize Third Party Resources through Premium Assistance** - It is incomprehensible why we choose to ignore the ability to share the costs of providing health care for our working families with employers. Failing to do so ignores a potential third party resource and drives up the costs and caseloads in the public programs. A state policy to assist families with the payroll deduction for employer-sponsored insurance with the state option for a full Medicaid wraparound would allow access to new provider networks and reduce costs significantly. The federal government should make it a priority to simplify the steps necessary to partner with the private sector to provide coverage.

6. **Pay Pharmacists as Service Providers** - Drug pricing is one of the most contentious areas in the Medicaid budget. We

have consistently tried to reduce the material cost of the drug and the dispensing fee paid to the pharmacist as a way of controlling costs. I think that in the future we should consider paying higher handling charges to the pharmacists provided that the amount paid for the ingredients in a prescription reflects the actual average sales price from manufacturers and distributors for the drugs with full transparency on pricing provided to federal auditors. We need the pharmacists as partners in the management of a complex benefit that now includes prior authorization, generic substitution, and consultation with a preferred drug list. The costs of the transaction for materials between the manufacturer and the pharmacist should not drive Medicaid costs.

7. **Pay providers for performance** – Physicians should be paid to provide treatments that follow evidence-based practice in a cost effective manner. Good quality care is usually less expensive.

Finally, I would say to those who oppose any Medicaid reform on principle, we will never reach anything like full coverage in this country with the current Medicaid model as the only option. The benefit is too rich and the costs are too high. Reserve traditional Medicaid for a population below the poverty level. But Reform must include some or all of these measures if we are to achieve success in a viable, sustainable Medicaid program.

That success benefits us all. As the recent hurricane experience demonstrates, public health does not distinguish amongst populations by payer. We all breathe the same air. We all drink the same water. Our bodies are subject to infection by the same microorganisms. The children of Medicaid are defending us today in Iraq and Afghanistan. Their brothers and sisters will care for us as we age. The program is vital to our national interest and deserves our best efforts to sustain it in the years to come.

All of us who care about Medicaid must not be enemies, but friends. Our disagreements may divide us on methods, but they should never divide us on principle. Surely with a common commitment to improving the health of the least fortunate of our neighbors we can discover, as Lincoln said, the better angels of our nature.

Thank you, I would be happy to answer any questions that you may have.